STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295052	A. BUILDING _____ B. WING _____	11/07/2008

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LIFE CARE CENTER OF LAS VEGAS	6151 VEGAS DRIVE LAS VEGAS, NV 89108

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility from November 4, 2008 through November 7, 2008. The census at the beginning of the survey was 226. Thirty one residents were sampled and 3 closed records reviewed. One complaint was investigated. Complaint # NV00019600 - Substantiated with no deficiencies Complaint # NV00018292 - Substantiated with deficiencies (F226) The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions, or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified.	F 000		
F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement procedures that prohibit neglect for 1 of 31 sample residents (#31).	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226	Continued From page 1 Findings include: Resident #31 A review of Resident #31's clinical records revealed he was a 65 year old male admitted to the facility on 2/5/08, with diagnoses of Osteomyelitis-Ankle, Decubitus Ulcer, UTI (Urinary Tract Infection), Paraplegia, General Muscle Weakness. According to the clinical records and interview with the Director of Nursing (DON), the resident was highly alert and oriented. A complaint investigation was initiated on 5/16/08 and concluded on 11/7/08, regarding an incident in which Resident #31 shot himself in the parking lot of the facility. According to the records and interviews with the DON and administrator, on 4/25/08, Resident #31 was out in the front parking lot in his wheelchair apparently waiting for the physical therapist (PT) who was leaving for the day. The records indicated that the resident told the therapist she was a good PT and then shot himself in the chest. The police were notified right away and the resident was taken by ambulance to an acute care facility . The police confiscated the gun the resident used to shoot himself. According to the medical records dated 3/26/08, Resident #31 was verbally abusive with staff and while in physical therapy, he verbalized he wanted to die. The resident was put on 15 minute checks, the physician was notified, and the resident was transferred to an acute care facility (Legal 2000) for a psychiatric evaluation. The care plan documented the patient stated,"If I had a gun, I would use it." The psychiatric	F 226		

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consultation was conducted and the assessment concluded, "Depression, not otherwise specified. The patient is currently not suicidal. He does not require psychiatric hospitalization." The resident was transferred back to Life Care and did not exhibit any suicidal ideation after the consultation. He was ordered Lexapro 10 mg (milligrams) PO (by mouth) QD (every day) by the MD (medical doctor) on 3/26/08, however this was discontinued by the MD on 3/30/08, as the patient refused the medication.

When questioned how Resident #31 acquired a gun, the administrator and DON indicated that they were unaware how he acquired it. They indicated that no gun was ever seen on the resident or in his room. The resident did not have family and had very few visitors. The only way he could have gotten the gun was when he left the facility without notifying staff.

The nurse's notes revealed that on 4/13/08 at 12:00 PM, the resident was not in his room for lunch. A search began inside and outside the facility and the resident was not found. Staff called the resident's cell phone but did not get an answer. Metro police was notified at 12:45 PM. At 3:15 PM, the resident was observed in front of the PT door getting out of a taxi. When questioned as to where he had been, he stated, "I went to my apartment to get a few things." When asked why he did not notify anyone, the resident stated, "I'm a big boy, I didn't think anyone would notice I was gone."

When Resident #31 exhibited suicidal behavior, the facility acted by doing 15 minute checks on the resident and transferring him to an acute care facility for psychiatric evaluation. The facility

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F 226	Continued From page 3 lacked evidence of a completed investigation and/or plan (policies and procedures) to prevent further incidents of this nature in the future. Complaint #NV00018292	F 226		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow a physician's orders for 1 of 31 sampled residents (#30). Findings include: Resident #30 Resident #30 was admitted to the facility on 9/6/08 and re-admitted on 10/8/08 with diagnoses including Muscle Weakness, Dysphagia, Hypertension, Diabetes, Cerebrovascular Accident, and a Percutaneous Endoscopic Gastrostomy (PEG) Tube. On the morning of 11/5/08, the licensed practical nurse (LPN) opened the medication cart and obtained a medication bubble pack labeled Glyburide 5 mg (milligrams) with Resident #30's name on the package. The LPN obtained 1 tablet from the packet, crushed the medication, and	F 309		

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F 309	Continued From page 4 administered the medication through Resident #30's PEG tube. A physician's order for Glipizide 5 mg was written on 10/12/08 for Resident #30. There was no documented evidence to administer Glyburide. The Director of Nursing (DON) contacted the ordering physician and confirmed the physician wanted Glipizide to be given and Glyburide should not have been given. The DON confirmed that the LPN did not follow the physician's order.	F 309		
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the environment as free of accident hazards as possible, for the residents in the locked unit, 100 unit, 200 unit, 300 unit, and 400 unit. Findings include: 1. On 11/4/08 at 4:30 PM, the locked unit had the following items unsecured in the rooms listed below: - Dining Room, an 8 ounce bottle of Purell hand sanitizer on an open shelf, near the water	F 323		

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F 323	Continued From page 5 dispenser and to the right of the doorway, - Room 107, Secura moisturizer lotion and a large plastic jar of Vaseline in the top unlocked cabinet drawer labeled A, - Room 109, Instyle Opium lotion, 3.3 ounces Snow Silk cologne, 8 ounces personal cleanser in the top unlocked cabinet drawer labeled A, and 8 ounces personal cleanser in the top unlocked cabinet drawer labeled B, - Room 111, 8 ounces of Periwash cleanser and a small plastic container of lotion in the top unlocked cabinet drawer labeled A, - Room 115, a small plastic container of yellow-colored mouthwash, lotion, and shampoo on the counter near the sink in the room, - Room 114, a small plastic container of shampoo and 8 ounces of personal cleanser on the counter near the sink in the room, - Room 116, a plastic container of McKesson shampoo, body wash, and lotion in the top unlocked cabinet drawer labeled A, and 3 small bottles of lotion in the top unlocked cabinet drawer labeled B, and - Room 117, 3 bottles of personal cleanser and a small bottle of lotion in the top unlocked cabinet drawer labeled A, and a small bottle of lotion in the top unlocked cabinet drawer labeled B. On 11/5/08 at 3:00 PM, the Unit Manager explained the personal care items were supplied by Central Supply and it was "okay" for the residents to have access to the items any time.	F 323		

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F 323	Continued From page 6 The Unit Manager was not sure if there was a policy regarding access to personal care items for residents in the locked unit and after searching reported there was no policy. The Unit Manager described when she worked on the locked unit the personal care items were kept in "baggies" in a locked cabinet in the shower/bathroom. On 11/5/08 at 3:35 PM, the Director of Nursing (DON) admitted there was no policy regarding access of personal care items for residents of the locked unit. The DON communicated the unlocked items were being gathered together and put under one lock because some locks in the resident rooms did not work. On 11/6/08 in the midmorning, 2 maintenance workers were seen working in room 117 on a lock of the top cabinet drawer labeled A. One maintenance worker in room 117 reported parts of some locks were missing. 2. On the morning of 11/7/08, Resident #30's wound treatment was being completed by the wound care nurse. The resident's right side of the bed was against the wall, the bed was elevated during the treatment, and the resident was laying on her right side facing the wall. Less that one foot away from Resident #30's face was a 4 socket red outlet. All 4 sockets were being used. The plugs along with the cords extended 2 to 3 inches from the wall socket. When Resident #30's bed was back in a regular position, entire bed down with the head of the bed at a 30 degree angle, the outlets were still visible at the residents head area and the plugs and cords were at reaching distance from the resident. Resident #30 was confused at times.	F 323		

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F 323	Continued From page 7 On the morning of 11/7/08, a tour of the facility was conducted to locate resident beds that were positioned against the walls. The beds that were positioned on their right or left side against the wall had visible outlets at the head or foot of the bed. The outlets located at the foot of the bed could possibly be kicked by a resident. The outlets next to the resident's head area could be reached by the residents or the resident's could pull the cords that were plugged into the outlet. The following rooms had beds that were positioned next to the wall and had outlets at the foot or head of the bed: -Room #117, 120, 123, 125, 128, 129, 130, 200, 205, 210, 212, 213, 215, 217, 218, 222, 224, 230, 231, 300, 309, 324, 326, 327, 400, and 412.	F 323		
F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure appropriate care of a resident's tracheostomy as per the	F 328		

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F 328	Continued From page 8 physician's orders for 1 of 31 residents (#8). Findings include: Resident #8 Resident #8 was a 37 year old female with diagnoses including COPD (Chronic Obstructive Pulmonary Disease), Laryngeal Cancer, Tracheostomy and PEG (Percutaneous Endoscopic Gastrostomy). Resident #8 was alert and oriented, walking throughout the facility independently and had the tracheostomy tube capped so she was able to talk. On 11/4/08 in the afternoon, Resident #8 was observed in her room and walking in the hallway. Resident #8's tracheostomy site was covered with a clean gauze around the tracheostomy tubing. On 11/5/08 in the morning, Resident #8 was observed in her room and walking in the hallway. The tracheostomy site appeared clean and covered with gauze around the tracheostomy tube. Physician's orders dated 9/15/08 at 3:00 PM, revealed - "Routine trach (tracheostomy) care every shift." Documentation on the Treatment Administration Record revealed that tracheostomy care was being done as follows: - September: September 15 - September 25 - Once a day during the day shift (AM - PM). September 26 - September 30 - No documentation that tracheostomy care was done. - October : Tracheostomy care documented on	F 328		

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F 328	Continued From page 9 10/07/08. There was no documented evidence that tracheostomy care was done on any other day during October. - November: Documentation indicated that tracheostomy care was being done once per shift. On 11/4/08 at 2:30 PM, the unit manager stated that tracheostomy care was generally done once a day according to the facility's policy. The unit manager confirmed a physician's order stated once per shift. She again stated that the nurses would still only do the treatment once a day according to the policy. Review of the facility's Respiratory Care Services Policy - Tracheostomy Care (Undated) revealed: "Procedure: 1. Verify physicians order to determine the frequency of trach care." On 11/5/08 at 1:45 PM, Employee #14 stated that Resident #8 generally changed her own dressing. There was no documentation that indicated the resident performed dressing changes herself. The registered nurse (RN) confirmed the physician's order stated every shift and documentation on the Treatment Administration Record was as indicated above.	F 328		
F 498 SS=D	483.75(f) PROFICIENCY OF NURSE AIDES The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced	F 498		

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F 498	Continued From page 10 by: Based on interview and review, the facility failed to ensure one Certified Nurse's Assistant (CNA) was competent to meet the needs of the residents in the area of communication. Findings include: On 11/5/08 at 10:00 AM, Employee #11 indicated she did not know who the abuse coordinator was. The Director of Nursing (DON) and the Staff Developer were present during the interview. Employee #11 was asked, what she would do if she saw a resident being abused. She indicated she did not understand the question. The Staff Developer repeated the abuse question in Spanish. Employee #11 answered correctly in Spanish. Employee #11 indicated she had a problem understanding English. On 11/7/08 in the morning, the Nurse Manager for the 200 Hall and the DON indicated Employee #11 was a good CNA (certified nursing assistant). She had been an employee of the facility since October 12, 2006. The Nurse Manager indicated Employee #11 had a problem understanding what was told to her in English. The DON indicated she was not "comfortable" asking anyone except the Spanish speaking CNAs for help. She sometimes would go to other halls in the facility to look for a Spanish speaking CNA. The Nurse Manager indicated Employee #11 did not follow directions because she didn't understand English very well. The Nurse Manager indicated Employee #11 did not converse with the residents due to a language barrier. If she did not understand a resident, she would find a Spanish/English speaking CNA to translate for her. The DON indicated she worked mostly alone because she did not understand	F 498		

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F 498	Continued From page 11 many of the non-Spanish speaking CNAs. On 11/7/08 in the morning, one resident who wished to remain anonymous indicated Employee #11 did not understand English and was always speaking Spanish. The resident indicated "She smiles a lot, but I don't think she understands." Employee #11 wrote a statement concerning an issue with a resident dated 2/19/08. The statement was written in Spanish with a typed statement by another employee translated into English. A Corrective Action Form dated 3/16/08, indicated Employee #11 refused to sign the statement because,..."Noacuerdo con esta causacion... (translated I don't agree with this accusation)." The Competency-Based Position Description and Performance Review Certified Nursing Assistant (CNA) Form indicated, "An essential function,...must be able to read, write and speak the English language..." A Competency-based Position Description and Performance Review for CNAs dated 2/2/07 and signed by Employee #11 stated, "...Areas for Improvement...1) Needs to improve in speaking and understanding the English language...". A Competency-based Position Description and Performance Review for CNAs dated 10/28/08 and signed by Employee #11 stated, ..."Areas for Improvement...2) English-needs to take a basic-formal English course; 3) Documentation more accurate..." The facility's Guidelines for Language Policy	F 498		

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F 498	Continued From page 12 indicated, "English should be spoken to residents unless they specify they want to speak another language (example: Spanish)."	F 498		